Conclusions: Early post-operative hypophosphatemia is an independent predictor of LRC. A simple LRC risk prediction tool that includes this variable accurately identified low-risk patients and may help identify those most likely to benefit from enhanced postoperative recovery pathways.

Table 1. LRC risk-score and a risk-prediction tool.

Risk-score[a]	Predicted risk of LRC	Risk-group	Predicted risk of LRC
0	4.3%	Low risk[b]	7.4%
1	8.2%		
2	20.7%	High risk[c]	25.1%
3	37.1%		

[a] Risk-score assigns 1 point for any of the following independent LRC predictors: hypophosphatemia on post-operative day 3, soft gland consistency, or intra-operative blood loss more than 400cc.

[b] Defined as any patient with a risk score of 0 or 1. This model identifies the low-risk group with a negative predictive value of 93%.

[c] Defined as any patient with a risk score of 2 or 3.

OP-I.46 SURVIVAL FOLLOWING PANCREATICODUODENECTOMY FOR STAGE 1A PANCREATIC ADENOCARCINOMA IS NOT IMPROVED BY MULTIMODALITY TREATMENT

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Introduction: Pancreaticoduodenectomy is an integral part of pancreatic adenocarcinoma treatment. NCCN guidelines recommend patients undergo multimodality therapy, but few studies validate its significance in early stage patients.
Methods: Using NCDB from 1998–2006, patients who underwent a pancreaticoduodenectomy were identified. Patients with invasive histology and stage 1 disease were included. X^2 test was used for categorical variables. Median survival was estimated using Kaplan-Meier method with log-rank comparison and Cox regression.
Results: Over 8 years, 2,801 patients were identified. Median overall survival for Stage 1A (n = 1047) and Stage 1B (n = 1776) was 31.8 and 23.2 months with a median overall follow-up of 23.7 months (0–172.9). Stage 1B patients were more likely to have higher grade tumors ($p = 0.002$), receive chemotherapy ($p = 0.007$) or radiation ($p = 0.002$) and have positive margins ($p < 0.0001$). There were no differences between groups with respect to lymph node yield (LN) or type of treatment facility. For both stages, chemotherapy, radiation, LN yield ≥17 nodes, age <70, tumor grade and facility type were associated with an improved overall survival on univariate analysis. However on multivariate analysis, for Stage 1A patients only LN yield ≥17 was independently predictive of survival while chemotherapy, radiation, facility type, age and sex had no impact on survival. For patients with Stage 1B, chemotherapy, age <70 and LN harvest ≥17 were associated with an improved overall survival on multivariate analysis.
Conclusion: Despite guidelines recommending multimodality treatment for pancreatic adenocarcinoma, there is no improvement in survival for patients with Stage 1A disease. A surgery only approach should be considered for these patients.

FRIDAY, MARCH 13, 2015, 6:30PM–7:30PM COCKTAIL VIDEO PRESENTATION

VC.01 TOTAL LAPAROSCOPIC CENTRAL PANCREATECTOMY WITH PANCREATIGOGASTROSTOMY FOR HIGH RISK CYSTIC NEOPLASM

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Background: Organ-sparing pancreatic resection is important in prophylactic surgery for cystic neoplasms. There is controversy regarding the optimal surgical approach for pancreatic lesions in the neck or proximal body of the pancreas. Central compared to distal pancreatectomy is technically more challenging but preserves more functional pancreatic tissue. Due to the prophylactic nature of the surgery and long survival of patients with benign and borderline malignant lesions, surgeons need to stratify greater importance to surgical morbidity and sparing pancreatic parenchyma.
Patient: The patient is a 59-year-old active woman with a symptomatic cystic neoplasm of the pancreas exhibiting high risk imaging features. The cyst of 2.2 × 1.8 cm in the body of the pancreas was impinging on the portal venous confluence.
Technique: The patient was positioned in the French Position, the lesser sac was opened and the pancreatic body exposed. A retropancreatic tunnel was created with staple division of the neck. The body was mobilized off the portal vein and splenic vessels transected. A retrogastric pancreaticogastrostomy was sewn through an anterior gastrotomy. The stent was delivered past the pylorus to decrease pancreatic enzymatic activation.
Conclusion: Laparoscopic ultrasound helps in defining cyst borders and minimal blood loss optimizes visualization during the dissection. A minimally invasive pancreaticogastrostomy created through an anterior gastrotomy is technically feasible and safe. This approach can minimize the morbidity of prophylactic pancreatic surgery for patients with cystic neoplasms. Nevertheless, it should not compromise safety, oncologic completeness or an organ-sparing approach.